

Report of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight to the 2019 Kansas Legislature

CHAIRPERSON: Representative Daniel Hawkins

VICE-CHAIRPERSON: Senator Vicki Schmidt

RANKING MINORITY MEMBER: Representative Barbara Ballard

OTHER MEMBERS: Senators Barbara Bollier (February and April), Bud Estes, Richard Hilderbrand, Laura Kelly, and Ty Masterson (August and November); and Representatives Susan Concannon, John Eplee, Kyle Hoffman (August and November), Jim Ward, and Chuck Weber (February and April)

CHARGE

KSA 2018 Supp. 39-7,160 directs the Committee to oversee long-term care services, including home and community based services (HCBS). The Committee is to oversee the savings resulting from the transfer of individuals from state or private institutions to HCBS and to ensure any proceeds resulting from the successful transfer be applied to the system for the provision of services for the long-term care system. Further, the Committee is to oversee the Children's Health Insurance Program (CHIP), the Program for All-Inclusive Care for the Elderly (PACE), and the state Medicaid program (KanCare), and monitor and study the implementation and operations of these programs, including, but not limited to, access to and quality of services provided and any financial information and budgetary issues.

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Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight

ANNUAL REPORT

Conclusions and Recommendations

The Committee expresses the following concerns and adopts the following recommendations:

- The Kansas Department for Aging and Disability Services (KDADS) request for proposal for high-touch administrative case management at the local level be monitored;
- A request be made for a report on progress made in nursing facility inspections toward compliance with federal and state law requiring inspections every 12 months;
- Recognizing suicide is the second leading cause of death among individuals ages 15-24 and ages 25-44 and the Kansas suicide rate in 2013 was 16.7 percent higher than the national average, according to the 2014 Kansas Annual Summary of Vital Statistics from the Kansas Department of Health and Environment (KDHE), the Committee expresses its concern to the Mental Health Task Force (Task Force) regarding the suicide rate and recommends the Task Force continue to study to identify causes and develop mitigating tools; and
- KDHE and KDADS continue to monitor and report to the legislative health and budget committees on the efforts to reduce the waiting lists for the Physical Disability and the Intellectual and Developmental Disability Home and Community Based Services waivers and the KanCare Medicaid eligibility backlog.

The Committee expresses concerns about the lack of preventive dental care for adult Medicaid recipients.

Proposed Legislation: The Committee requests the following:

- A Committee bill to increase the protected income limit cap (KAR 129-6-103 (13)(c));
- A Committee bill be pre-filed to restore the Temporary Assistance for Needy Families eligibility profile to its 2010 level; and
- The 2018 dental therapist bill (2018 SB 312, as it passed the Senate) be reintroduced as a Committee bill in the 2019 Legislative Session.

BACKGROUND

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services (HCBS) and KanCare Oversight operates pursuant to KSA 2018 Supp. 39-7,159, *et seq.* The previous Joint Committee on HCBS Oversight was created by the 2008 Legislature in House Sub. for SB 365. In HB 2025, the 2013 Legislature renamed and expanded the scope of the Joint Committee on HCBS Oversight to add the oversight of KanCare (the State's Medicaid managed care program). The Committee oversees long-term care services, including HCBS, which are to be provided through a comprehensive and coordinated system throughout the state. The system, in part, is designed to emphasize a delivery concept of self-direction, individual choice, services in home and community settings, and privacy. The Committee also oversees the Children's Health Insurance Program (CHIP), the Program for All-Inclusive Care for the Elderly (PACE), and the state Medicaid programs.

The Committee is composed of 11 members: 6 from the House of Representatives and 5 from the Senate. Members are appointed for terms that coincide with their elected or appointed legislative terms. The Committee is statutorily required to meet at least once in January and once in April when the Legislature is in regular session and at least once for two consecutive days during both the third and fourth calendar quarters, at the call of the chairperson. The Committee is not to exceed six total meetings in a calendar year; however, additional meetings may be held at the call of the chairperson when urgent circumstances require such meetings. In its oversight role, the Committee is to oversee the savings resulting from the transfer of individuals from state or private institutions to HCBS and to ensure proceeds resulting from the successful transfer be applied to the system for the provision of services for long-term care and HCBS, as well as to review and study other components of the State's long-term care system. Additionally, the Committee is to monitor and study the implementation and operations of the HCBS programs, CHIP, PACE, and the state Medicaid programs, including, but not limited to, access to and quality of services provided and financial information and budgetary issues.

As required by statute, at the beginning of each regular session, the Committee is to submit a written report to the President of the Senate, the Speaker of the House of Representatives, the House Committee on Health and Human Services, and the Senate Committee on Public Health and Welfare. The report is to include the number of individuals transferred from state or private institutions to HCBS, as certified by the Secretary for Aging and Disability Services, and the current balance in the HCBS Savings Fund. (See Appendix A for the 2018 report.) The report also is to include information on the KanCare Program, as follows:

- Quality of care and health outcomes of individuals receiving state Medicaid services under KanCare, as compared to outcomes from the provision of state Medicaid services prior to January 1, 2013;
- Integration and coordination of health care procedures for individuals receiving state Medicaid services under KanCare;
- Availability of information to the public about the provision of state Medicaid services under KanCare, including access to health services, expenditures for health services, extent of consumer satisfaction with health services provided, and grievance procedures, including quantitative case data and summaries of case resolution by the KanCare Ombudsman;
- Provisions for community outreach and efforts to promote public understanding of KanCare;
- Comparison of caseload information for individuals receiving state Medicaid services prior to January 1, 2013, to the caseload information for individuals receiving state Medicaid services under KanCare after January 1, 2013;
- Comparison of the actual Medicaid costs expended in providing state Medicaid

services under KanCare after January 1, 2013, to the actual costs expended under the provision of state Medicaid services prior to January 1, 2013, including the manner in which such cost expenditures are calculated;

- Comparison of the estimated costs expended in a managed care system of providing state Medicaid services before January 1, 2013, to the actual costs expended under KanCare after January 1, 2013; and
- All written testimony provided to the Committee regarding the impact of the provision of state Medicaid services under KanCare upon residents of adult care homes.

All written testimony provided to the Committee is available through Legislative Administrative Services.

In developing the Committee report, the Committee is also required to consider the external quality review reports and quality assessment and performance improvement program plans of each managed care organization (MCO) providing state Medicaid services under KanCare.

The Committee report must be published on the official website of the Kansas Legislative Research Department (KLRD). Additionally, the Kansas Department for Aging and Disability Services (KDADS), in consultation with the Kansas Department of Health and Environment (KDHE), is required to submit an annual report on the long-term care system to the Governor and the Legislature during the first week of each regular session.

COMMITTEE ACTIVITIES

The Committee met twice during the 2018 Session (February 16 and April 23) and twice for two days each during the 2018 Interim (August 20 and 21 and November 8 and 9). In accordance with its statutory charge, the Committee's work focused on the specific topics described in the following sections.

KanCare Overview and Update

At each meeting, the KDHE Medicaid Director and Director of Health Care Finance (Medicaid Director) provided the following: KanCare program updates, including the status of the State's Section 1115 waiver application, the KanCare request for proposal (RFP), KanCare utilization and cost comparison data, the MCOs' financial status, and a corrective action plan (CAP) update; stakeholder and legislative engagement efforts; KanCare data and analytics; updates on the Medicaid eligibility application backlog; efforts to address the opioid epidemic and anti-psychotic use in nursing homes; and a KanCare Executive Summary containing data on eligibility and expenditures, financial summaries, the provider network, medical loss ratio, claims, value-added and in-lieu-of services, and grievances, appeals, and fair hearings received. (*Note: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program.*)

At the February 16 meeting, the Medicaid Director stated an intention to change the culture of the agency to be more positive in responding to the challenges of administering KanCare. The Medicaid Director traced updates on KDHE's compliance with 2017 Senate Sub. for HB 2026 and preliminary results of the Working Healthy program. (*Note: Senate Sub. for HB 2026 [2017], among other changes, requires MCOs to provide certain education and training, provide documentation in certain situations, pay nursing facilities with a change in ownership, and prohibits discriminating against any licensed pharmacy or pharmacist located within the geographic coverage area of the MCO. The bill also requires KDHE to procure the services of an independent auditor to review, at least once per calendar year, a random sample of all claims paid and denied by each MCO and the MCO's contractors.*)

At the April 23 meeting, the Secretary of Health and Environment commented on how to integrate Medicaid and public health and improve health care financial performance. The Secretary provided a summary of services and payments across the MCOs and the average cost per service.

The Medicaid Director noted a Medical Assistance Program identifier will be federally required for all Medicaid providers by January 1, 2019, to receive payment on claims. (*Note:* A National Provider Identifier is a unique identification number for covered health care providers.) The second iteration of the provider module for integrated credentialing will go live on January 1, 2019, creating a single access point for providers to receive credentialing with the State and all three MCOs at one time; the credentialing will follow the three-year intervals for MCO credentialing. The Medicaid Director concluded by announcing the CAPs listed had all been completed; KDHE was waiting for the system to be implemented for the adverse interactions. The Medicaid Director also stated the increased provider rates would go into effect on September 1, 2018, and claims paid in June and July 2018 would be reprocessed at the higher rate.

At the November 8-9 meeting, the Medicaid Director briefly touched on the status of legislative-funded programs: OneCare Kansas (Health Homes), reinstatement of Medicaid post incarceration, mid-year rate adjustment, telehealth, and juvenile crisis centers. The Medicaid Director noted future fiscal notes on bills impacting KDHE will include an implementation timeline to provide legislators with information to better determine a realistic effective date. The Medicaid Director requested more input from legislators regarding the 2018 Kansas Telemedicine Act (Senate Sub. for HB 2028); the Medicaid Medical Director (Medical Director) reported KDHE was following Centers for Medicare and Medicaid Services (CMS) guidelines as a first step but wanted to ensure legislative intent is being met. The Medicaid Director discussed questions to be addressed to implement the Juvenile Crisis Center legislation (2018 House Sub. for SB 179).

KanCare 2.0

Section 1115 waiver renewal application. At the February 16 meeting, the Medicaid Director noted the State's Section 1115 waiver (KanCare 2.0) application had been accepted by CMS, and CHIP had been reauthorized.

At the April 23 meeting, the Medicaid Director traced the Section 1115 waiver application timeline and the adjustments being

made to the KanCare program (referenced as KanCare 1.x). (*Note:* The term KanCare 1.x was used to reference the Section 1115 waiver application without the changes prohibited by the legislative budget proviso in 2018 House Sub. for SB 109, Section 118.) The adjustments to the Section 1115 waiver would be focused on the following hypotheses proposed by KDHE: value-based reimbursements will further integrate physical and behavioral health services; increasing employment and independent living supports to provide opportunities for individuals with a disability or a behavioral health condition will help them become more independent; telehealth will enhance access to care in rural, semi-rural, and underserved areas; and removing barriers for services provided in institutions for mental diseases (IMDs) will result in improved access to services and better health outcomes. CMS limits the State's reimbursement for IMDs. KDHE will be seeking a waiver from CMS for full reimbursement of the whole spectrum of substance use disorders (SUD) and co-occurring SUD and mental health conditions services provided within IMDs.

The Medicaid Director indicated KDHE's direction regarding the Section 1115 waiver application moving forward was that KDHE would continue to consider the possibility of work requirements in the future, but without a lifetime limit on eligibility. The Medicaid Director stated discussions with CMS would be clear that no changes to KanCare eligibility will be implemented until at least July 1, 2019, or January 1, 2020, to allow input from the Legislature. The Medicaid Director indicated the lifetime limit on eligibility included in the Section 1115 waiver application filed with CMS could be removed through language in the special terms and conditions to that effect or, if requested by CMS, by filing an amendment to the application.

The Medicaid Director stated at the August 20-21 meeting KDHE was meeting weekly with CMS to finalize an extension of the Section 1115 waiver; approval was anticipated in November 2018. The work opportunities for persons with disabilities program was included, but could not be implemented until July 1, 2019, to allow for legislative input. The work requirement will not be implemented without legislative approval. The legislative-funded telehealth initiative was nearing

readiness to go live January 1, 2019. The Medicaid Director stated the IMD SUD exclusion is under behavioral health and the agency can move forward with the exclusion without violating the legislative budget proviso (2018 House Sub. for SB 109, Section 118) prohibiting certain changes to the January 1, 2018, version of KanCare program without legislative approval.

The Medicaid Director noted at the November 8-9 meeting CMS approval of the Section 1115 waiver extension was still anticipated in November, with the only new program included being the IMD exclusion for SUDs to allow for reimbursement for SUD services within IMD facilities. (*Note:* The Section 1115 waiver extension was approved by CMS on December 18, 2018.) The Medicaid Director commented, pursuant to the legislative budget proviso prohibiting any other changes to the Medicaid program as it existed on January 1, 2018, any other new program proposed in the waiver extension was being postponed until at least July 1, 2019.

Compliance with KanCare proviso. Committee members expressed concern KDHE was not following a legislative budget proviso included in the 2018 Omnibus Budget bill for fiscal year (FY) 2018 and FY 2019 (2018 House Sub. for SB 109, Section 118) that required a hiatus in the changes proposed by the KanCare 2.0 Section 1115 waiver application. At the August 20-21 meeting, the Medicaid Director stated there was ongoing litigation on this issue. The Medicaid Director noted changes KDHE would like to consider to improve the system: improvement of network adequacy to ensure persons are receiving needed services; implementation of required CMS regulations; removal of the requirement that people with disabilities must request a continuation of services after ten days; and changes to eligibility, such as the protected income limit (PIL). However, the Medicaid Director stated these would be changes to the program as it existed on January 1, 2018, and would be prohibited by the proviso.

With regard to concerns that the process of changing MCOs will be too expensive, the Medicaid Director stated all the programs that were identified as cost drivers (*e.g.*, community service coordination, work requirements, MediKan

initiative, and work opportunities for people with disabilities) had been moved to an implementation date of July 1, 2019, or later, to allow for legislative input during the 2019 Legislative Session. Although these items are being discussed, the Medicaid Director stated they would not go live on January 1, 2019.

The Medicaid Director stated the waiver hypotheses with the Section 1115 waiver had been adjusted to reflect four new assumptions on which favorable input was received at the November 2017 meeting of this Committee: value-based reimbursement models will fully integrate physical and behavioral health care; increasing employment independent living supports will help people become more independent; the use of telehealth will enhance access to care in rural, semi-rural, and underserved areas; and removing payment barriers to services provided at IMDs will result in improved access to service and better health outcomes.

An Assistant Revisor, Office of Revisor of Statutes, reviewed the language of the proviso with the Committee, including the requirement for legislative prior authorization for any changes in the manner in which KanCare managed care services are provided that are “substantially different” than the manner in which those services were provided on January 1, 2018, including changes to the eligibility requirements.

The Medicaid Director assured Committee members KDHE had not implemented any changes included in KanCare 2.0 and would follow the directives of the proviso. It was reported the agency was moving forward with readiness reviews to ensure the MCOs can operate the requirements of managed care in the state. The Medicaid Director confirmed the proviso is in place until July 1, 2019, and KanCare 1.x will be in place in 2018 and 2019 until the Legislature has an opportunity to consider the changes desired. The Medicaid Director noted, should the Legislature choose to include the work requirements during the 2019 Session, KDHE would have to amend the waiver to implement the work requirements. The Medicaid Director agreed with a Committee member who stated the work requirements would not be a cost reduction measure.

Request for proposal. At the April 23 meeting, the Medicaid Director stated the KanCare 1.x RFP, initially issued as the KanCare 2.0 RFP, was in the procurement process. The Medicaid Director stated the technical review and cost proposal review had been completed, and KDHE would be meeting with the bidders in the future. The RFP process is used to select entities to provide KanCare services and does not address the waiver application process regarding eligibility conditions for receipt of benefits.

The Secretary of Administration reported on the status of the RFP for the KanCare contract at the August 20-21 meeting. The process, which went out for bid in November 2017, went through June 2018. During this time period, there were multiple legislative hearings, discussions with the vendors, and meetings with the agencies. In June 2018, contracts were awarded to three of the six vendors after evaluation of the submitted bids. The Secretary said, following the award of the contracts, all three unsuccessful bidders (including Amerigroup Kansas Plan [Amerigroup], which provided managed care services under the initial KanCare contract) protested, which is not unusual for a contract of this magnitude. The Department of Administration, Office of Procurement and Contracts, responded to and denied the bid protests. The State was into a judicial review process as a result of a lawsuit filed by Amerigroup against the State. There were hearings in early August 2018 about whether the State could go forward with the contracts while the rest of the litigation was ongoing. The State was successful in arguing it would be detrimental to the State to stop the process at that time. The State would be moving forward under the terms of the contracts while the remaining issues were litigated. The Secretary stated the subject of the litigation was whether the process was fair to all six bidders and whether the decisions made by the state agencies and the Department of Administration were arbitrary or based on the documentation and facts available. The case was on an expedited schedule and hearings in September 2018 were anticipated. The new MCO contracts with Aetna Better Health of Kansas, Inc. (Aetna), Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare) will go into effect on schedule, January 1, 2019, barring a judicial ruling to the contrary. The three-year contract provides an

option to renew. The Medicaid Director added all KDHE contracts have a termination clause but do not typically impose penalties for termination.

The court issued a decision on October 12, 2018, denying Amerigroup's complaint and dismissing the case. At the November 8-9 meeting, the Medicaid Director confirmed all litigation surrounding the MCO contract issuance was completed.

Addressing concerns with the process of changing MCOs, the Medicaid Director noted at the August 20-21 meeting there was flexibility in the process to alter the program so as not to bind the next administration. The contracts with the MCOs and the Section 1115 waiver being negotiated with CMS are for three years with two one-year extensions, with the option to terminate or amend.

The Medicaid Director stated open enrollment was for all KanCare members, not just those currently enrolled with Amerigroup. Any members enrolled with Amerigroup who did not make an MCO choice at open enrollment would be enrolled with Aetna.

The Medicaid Director stated at the November 8-9 meeting KDHE was working to make the transition to Aetna as smooth as possible in order to ensure continuity of care for individuals. He shared a few key elements in the continuity of care: no reduction in the existing plan of care for 90 days, unless the member specifically requests the reduction in services; MCOs without a contract with an existing provider would have to pay 100.0 percent of the fee schedule; and existing prior authorizations for drugs or services would remain in effect for the first 90 days to allow time for the prior authorizations to be provided to the new MCO and time to reassess the members' needs. KDHE had scheduled go-live phone support sessions in January 2019 to answer member and provider questions. The Medicaid Director stated, on January 1, 2019, KDHE will go live with a new version of the provider portal that will include a prior authorization form and a single provider credentialing form for every provider to be used by the three MCOs as required by 2017 Senate Sub. for HB 2026.

At the November 8-9 meeting, the Medicaid Director provided an update on the status of the KanCare MCO contracts to begin in 2019. The Medicaid Director noted the MCO contracts were signed in July 2018, and the parties finalized an amendment to specify the contract length is for three years with two one-year extensions. The parties were working on a second amendment for 2019 rate setting. The Medicaid Director noted, if KDHE decided not to extend the new contract with an MCO beyond the three years, an RFP would need to be issued by the end of 2019 to allow sufficient time for the RFP process to run its course and have a new MCO in place prior to the end of the existing three-year contract. The Medicaid Director clarified the contract contains a termination clause that allows KDHE to terminate within 30 days but reminded Committee members of the lengthy period of decommissioning that would follow.

MCO readiness review process. The Medicaid Director described the readiness review process at the August 20-21 meeting, which was under way to ensure the three MCOs under the new KanCare contract would be ready to process claims and enroll providers by January 1, 2019. Public meetings for providers and members were scheduled to communicate the changes beginning January 1, 2019, and possible future changes.

KanCare Utilization and Data Analytics

At the February 16 meeting, the Medicaid Director stated KDHE had signed an agreement with the Kansas Health Institute (KHI) to process data and was building a partnership with the University of Kansas School of Medicine for more accurate data. The Medicaid Director wanted a data analytics stakeholder group by October 2018 to work on providing more accurate statistics. The Chairperson requested one member each from the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare be on the data analytics stakeholder group and suggested a specific representative.

At the April 23 meeting, the Medicaid Director stated a KDHE data analysis team review of the KanCare utilization data indicated the numbers did not match what had been previously provided to the Committee. To address this matter, KDHE obtained the services of an independent

data analyst and combined that analysis with an analysis by the KDHE data analysis review team, resulting in what the agency believed was a more accurate representation of KanCare utilization. New data analytics were provided comparing 2012 and 2016 KanCare and HCBS waiver utilization and KanCare cost comparisons.

KDHE Analytics Division. At the November 8-9 meeting, the Director of Finance and Informatics, KDHE, discussed the strategic goals of the Analytics Division. KDHE entered into partnership with DXC Technology (DXC) and Cerner. DXC had been the fiscal agent handling claims processing and fiscal responsibilities for some time. Cerner was fairly new to the agreement and would handle the analytical capabilities. The Director reported on the development of the Enterprise Data Warehouse (EDW) that is operational but not yet complete. Stage 1 had been completed with the transfer of data from the legacy system to the EDW, allowing for the pulling of data to do the analytics. Stage 2 would bring in ancillary data sources, such as data available to KDADS to make Medicaid eligibility determinations. Public health data could also be brought into the EDW at a later date to provide a more complete picture of the Medicaid beneficiaries as a whole. Some of the analytical goals developed during the KDHE quarterly strategic meetings with DXC and Cerner were provided.

The Medicaid Director provided data comparing KanCare utilization for 2017 to pre-KanCare (2012) for all KanCare programs and HCBS waivers. The Medicaid Director provided some possible solutions to address the 6.0 percent decline in KanCare utilization for dental services from 2016 to 2017. Committee members were reminded that Medicaid covers only dental services for children, with adults qualifying only for emergency extractions and any other adult dental services being provided as a value-added benefit by the MCOs.

KanCare Meaningful Measures Collaborative (KMMC). At the April 23 meeting, a representative of KHI commented on collaborative efforts between KHI and KDHE to provide staffing and data analytics, the KMMC. The Chairperson suggested an outline of this collaborative initiative be considered at the

Committee's third-quarter meeting to allow for Committee input on the collaborative.

A roundtable discussion of the KMMC data initiative, led by a representative of KHI, was held at the August 20-21 meeting. The initiative includes 40 diverse groups, all of whom have an interest in the success of KanCare. The endeavor would, from the data available, develop a data network to include transparency, performance measures, and other metrics that would increase the usefulness of the broad spectrum of information. The purpose is to create a data repository to make information more readily available and useful. The scope of the project was presented. The group includes consumers, stakeholders, state agencies, and the research community.

For the group to function efficiently, an Executive Committee was established. The Executive Committee members stated the plan is to upgrade the technology, increase training in order to accomplish the goals, build a process that is sustainable, and then standardize the data. Additionally, two work groups were formed—the Data Resource Work Group and the Stakeholder Work Group—to provide an opportunity for additional focused input in the work of the KMMC. A list of members for the Executive Committee and each of the work groups was provided. Members of the Executive Committee and the work group members shared the focus of the respective groups.

The Secretary of Health and Environment and the Secretary for Aging and Disability Services stated, respectively, KDHE and KDADS fully support the initiative and noted the Executive Committee played an important role in balancing the desires of stakeholders and providing focus for the group.

A KHI representative summarized the presentations by noting the importance of proceeding in a timely manner and expressed the desire to build a system that will be a model for the country. The KHI representative noted funding sources had yet to be established, but the system should not require expensive maintenance. The importance of access to state infrastructure was stressed and a public/private partnership was

suggested. The KHI representative stated the group would maintain an arms-length process with state agencies and no budget had been proposed yet for the group. A Committee member commented costs related to the project could affect agency budgets more than the State General Fund (SGF). Further meetings of the group were planned, and the group expected to make an official presentation to the Legislature and update the Committee at the beginning of 2019. The Chairperson also requested regular reports to the Committee.

At the August 20-21 meeting, the Commissioner for Community Services and Programs, KDADS, provided the timeline for consideration and implementation of proposed metrics for HCBS quality measurements, which would be incorporated into the KMMC.

At the November 8-9 meeting, a KHI representative outlined the progress of the KMMC. The representative stated, by the end of 2018, the working groups would provide basic inventory and a data map, and, early in 2019, would have additional details for the data map and would provide a priority list of measures. In-kind funding was being provided by participating organizations and state agencies; other funding came from the REACH Healthcare Foundation. A beta KMMC website would be developed under the leadership of the Kansas Foundation for Medical Care (KFMC).

Clearinghouse

Medicaid Eligibility Backlog

At the February 16 meeting, the Medicaid Director informed the Committee, as of February 7, 2018, the number of unprocessed Medicaid applications past the 45-day requirement for an application to be processed was 5,407. At the April 23 meeting, the reported number of unprocessed applications (both active and pended) at the end of March 2018 past the 45-day processing requirement was 4,854 (257 Family Medical, 4,241 Elderly and Disabled, and 356 Long Term Care [LTC]). Additionally, there was a backlog of reviews past the 45-day requirement as follows: 539 Family Medical, 1,053 Elderly and Disabled, and 728 LTC. At the August 20-21 meeting, the reported number of unprocessed applications (both

active and pending) at the end of July 2018 past the 45-day processing requirement was 1,450 (673 Family Medical, 349 Elderly and Disabled, and 428 LTC). The review backlog past the 45-day requirement was as follows: 364 Family Medical, 30 Elderly and Disabled, and 90 LTC. At the November 8-9 meeting, the reported number of unprocessed applications (both active and pending) at the end of October 2018 past the 45-day processing requirement was 825 (151 Family Medical, 335 Elderly and Disabled, and 339 LTC). The review backlog past the 45-day requirement was as follows: 59 Family Medical, 29 Elderly and Disabled, and 22 LTC. The Medicaid Director provided charts to the Committee showing the numbers of unprocessed applications past 45 days by category and by month from January 2018 to October 2018.

Oversight of Maximus

CAP and innovations. At the February 16 meeting, the Medicaid Director stated CAP tasks were 92.0 percent completed. The metrics built into the contract with Maximus were discussed. The Medicaid Director also noted, if Maximus had not resolved the issues with the Clearinghouse by June 1, 2018, liquidated damages for contract noncompliance would be retroactive to January 20, 2018.

The Medicaid Director reported at the April 23 meeting daily calls by KDHE to Maximus regarding the Clearinghouse deficiencies had brought some improvement. The Medicaid Director stated a budget request was made for 25 additional positions to assist in improving response time for applications. A significant drop in Family Medical reviews resulted in further work with Maximus. Changes in the eligibility processing system were expected to result in better progress with the Elderly and Disabled programs, which continued to have a large number of applications. The numbers of LTC applications and reviews had trended down. The expansion of the Liaison Pilot program to assist LTC facilities with application resolution was ongoing, with the expectation all 360 LTC facilities would soon be included in the program. Nursing home survey results provided showed a significant increase in satisfaction with the Liaison Pilot program.

The Medicaid Director stated KDHE had developed an eligibility charter with key priorities for the KanCare program. Among the measures being considered by KDHE if Maximus did not meet the contract expectations by June 1 was the possibility KDHE would assume portions of the Maximus responsibilities in those areas where KDHE would be able to provide better service with the least disruption to beneficiaries. The Medicaid Director listed several eligibility innovations expected to enhance the effectiveness of the eligibility process.

Maximus contract. At the August 20-21 meeting, the Secretary of Health and Environment reported the contract agreed to with Maximus, which was not then signed, would extend the partnership through 2019. Under the terms of the contract, KDHE would assume responsibility for training and quality beginning January 1, 2019, and KDHE would consider directly managing other aspects of application processing in 2019. The contract would cost KDHE an additional \$2.0 million, all from the SGF, but KDHE had no budget authority for the increased cost of the Maximus contract. The Finance Council would have to agree to fund the added cost.

In response to questions about the contract, the Secretary stated, in the future, Maximus would be accountable for fewer metrics; in the short term, it did not appear possible to make the Maximus decision cost neutral; it did not make sense to bring in a third party to assume Medicaid application processing, and the State is not in a position to take on the task; as part of the negotiations, up to \$10.0 million in concessions would be received; Maximus applied staff beyond the requirement in the prior contract; beyond 2019, KDHE would consider a new contract with a different vendor; and the \$2.0 million increase in the Maximus contract for FY 2019 includes funds for KDHE to prepare for its additional responsibilities and payment to Maximus.

The Secretary acknowledged continued eligibility backlogs at the Clearinghouse at the November 8-9 meeting. The Secretary explained the contract with Maximus had been finalized and would expire June 30, 2019, with a six-month option for the latter half of 2019. Beginning on January 1, 2019, under Phase I, the KDHE Division of Health Care Finance would assume

responsibility for the training and quality functions of the Clearinghouse staff. Phase I would also require subleasing additional space and hiring 27 employees. The Secretary stated the Medicaid eligibility application backlog was at its lowest point since the State entered into a contract with Maximus in 2013, but much work remained to be done. No decision had been made regarding KDHE's future relationship with Maximus.

The Secretary further stated KDHE recommendations for Phase II are pending approval from the Governor-elect. Decisions would need to be made quickly to enable the State to assume the additional responsibilities before the expiration of the Maximus contract. Under the proposed Phase II, the KDHE Division of Health Care Finance would assume the responsibility for Elderly and Disabled and LTC Medicaid determinations from Maximus on July 1, 2019. An additional 241 state employees would need to be hired to begin training on April 1, 2019, to make determinations on these more complex cases. Phase II would require the State to lease an additional facility to house the additional employees. As of July 1, 2019, Maximus would focus solely on processing Family Medical and CHIP applications.

The liquidated damages, as of the November 8-9 meeting, that KDHE had been able to assess on Maximus as a result of the contract negotiation were reported.

Opioid Policies

The KDHE Chief Health Officer and Medicaid Medical Director (Medical Director) reviewed Medicaid opioid policies at the February 16 meeting. The Medical Director stated a new opioid use for pain management prior authorization was approved by the Drug Utilization Review (DUR) Board in January 2018 and was to be implemented on May 1, 2018.

At the April 23 meeting, the Medical Director said policies were being developed to address short-term and chronic opioid users. Additionally, Kansas was selected for the Medicaid Innovation Accelerator Program to address opioid use.

The Medical Director stated at the August 20-21 meeting that a Medicaid opioid strategy for

pain management was developed, and a Substance Use Disorder Task Force (Task Force) was created and had met five times since April 2018. Details regarding the pain management program were provided, indicating a new push to make the individual more functional, but not necessarily pain free. At the November 8-9 meeting, the Medical Director reviewed a few of the 34 high-priority recommendations of the Task Force, which included creating a central authority to develop goals, objectives, and processes; increasing provider training; and requiring provider registration in Kansas Tracking and Reporting of Controlled Substances (K-TRACS), using K-TRACS to educate providers, and obtaining funding to continue K-TRACS. The Medical Director confirmed the Task Force recommendations included the expansion of Medicaid, and the Task Force report was provided to the Governor on September 1, 2018. The Director indicated some of the recommendations could be instituted by executive order, but Medicaid expansion was not one of them.

There was discussion at the November 8-9 meeting as to whether there should be a requirement for mandatory use of K-TRACS in addition to mandatory K-TRACS registration. The Medical Director agreed there should be mandatory use of K-TRACS, but KDHE would be proceeding with mandatory registration first and then would consider making use mandatory for those providers who prescribe controlled substances. Another member recommended caution for KDHE as it moves forward with mandatory K-TRACS registration and listed several considerations that would need to be addressed. A Committee member urged the Legislature to find sufficient funding to continue the program and update it as needed for effectiveness since long-term funding for K-TRACS has not been solidified.

The Medical Director also discussed the Medicaid opioid policy and prior authorization criteria for opioid products indicated for pain management and KDHE's use of the Centers for Disease Control and Prevention guidelines regarding limitations on the prescribing of opioids.

Anti-psychotic Drugs for Dementia Patients

At the February 16 meeting, the Medical Director discussed the goal of reducing the use of anti-psychotic drugs in patients with dementia. A prior authorization draft was proposed to the Mental Health Medicaid Advisory Committee on February 13, 2018, and once approved would be proposed to the DUR Board for final approval. At the April 23 meeting, the Medical Director stated a draft policy was being considered to reduce anti-psychotic drug use for dementia patients.

At the August 20-21 meeting, the Medical Director stated the off-label use of anti-psychotic drugs in the Medicaid LTC population for the non-dual eligibility group 65 years of age and older had dropped by 28.0 percent. New DUR Board-approved criteria to address anti-psychotic drug use for dementia patients will require a diagnosis for approval of anti-psychotics in patients 65 years of age and older in the LTC non-dual eligibility group setting.

At the November 8-9 meeting, the Medical Director stated the prescribing of anti-psychotic drugs requires a proper diagnosis or a risk of imminent harm to the patient or others. The Medical Director noted adequate staffing levels in LTC facilities could minimize the use of anti-psychotic drugs, and low Medicaid reimbursement rates threaten the survival of some nursing homes.

The Secretary for Aging and Disability Services stated at the November 8-9 meeting Kansas ranked 51st in the nation in 2011 in the use of anti-psychotic drugs in nursing facilities; Kansas now ranks 38th in the nation; and continued improvement was expected based on the activities undertaken.

Step Therapy Cost Avoidance

The Medical Director noted at the November 8-9 meeting the state's Medicaid program cost avoidance through the use of step therapy for all implemented step therapies from September 2016 through September 2018 was \$7,085,665.

Claims Processing

In response to a Committee member's question at the February 16 meeting regarding

reports on claims processing being skewed by the large number of pharmacy claims that are processed instantaneously, the Medicaid Director indicated he would amend the reporting template to better identify the data reported. At subsequent meetings, KDHE provided data that differentiated between instantaneously approved pharmacy claims and all other claims.

Managed Care Organizations' Financial Update

KDHE provided testimony indicating the adjusted net income (loss) of the MCOs through June 2018 was as follows: Sunflower, \$3,440,034; UnitedHealthcare, \$2,447,025; and Amerigroup, \$15,457,536.

KanCare Audit Report

A Principal Auditor, Legislative Division of Post Audit (LPA), reviewed a recent audit of KanCare at the August 20-21 meeting. The audit addressed a single question: "What effect did transitioning to KanCare have on the State's Medicaid costs, the services provided, and client health outcomes?" The Principal Auditor stated, during the first year of KanCare (2013), state payments to the three MCOs were about \$400 million less than what the MCOs paid in provider claims; however, by 2015, state payments to the MCOs exceeded what the MCOs paid in provider claims by about \$400 million. State payments to the MCOs grew from \$2.1 billion in 2013 to \$3.0 billion in 2016. In regard to Medicaid services during the same period, KanCare increased the use of primary, dental, behavioral health, and nursing facility care, but had little to no effect on inpatient care. The Principal Auditor noted that because of insufficient data, KanCare's effect on Medicaid health outcomes was inconclusive. The Principal Auditor also noted ancillary findings, citing the issue of timeliness and accuracy of claim payments. The audit offered one recommendation: KDHE should take steps to ensure accurate claims data. To accomplish this, the audit recommended KDHE sample Medicaid claims to determine whether interest penalties are inflated and require reimbursement.

KDHE Response to KanCare Audit Report

The Medicaid Director responded to the LPA audit, noting capitation payments include more

than the cost of services. As an example, the Medicaid Director stated a 7.0 percent administrative allowance and a 1.0 percent profit allowance are added to the cost of services, as are Supplementary Medical Education and Health Care Access Improvement Program costs required by CMS based upon utilization. In addressing the approximately \$400 million less in payments to the MCOs in 2013 than were paid by the MCOs in provider claims, the Medicaid Director stated risk corridor payments had to be made because the capitation rates were not set up appropriately at the onset of KanCare. With regard to the approximately \$400 million more in state payments to the MCOs in excess of claims paid to providers by the MCOs, the Medicaid Director explained the excess in state payments was actually about \$80 million when the required portions that make up the capitation payments, other than the cost of services, were taken into account. Additionally, the failure to process Medicaid eligibility renewals added \$60.4 million in 2015 to the cost. The end result is \$19.6 million in excess of claims paid, which is reasonable if the MCOs are managing the KanCare population well.

The Medicaid Director also noted, beyond the demographics of the Medicaid population, factors such as changes in CMS incentives and regulations, legislative action, and fee schedule increases could also drive the expenditures of a program. In order to definitively say the program itself was what increased the cost, if there was a cost increase, these other factors would have to be tracked and controlled.

In addressing the audit report with regard to service use, the Medicaid Director agreed with the report, except for the data related to inpatient use. The Medicaid Director noted there are data issues with Medicaid and provided examples at the federal level, stating the data CMS receives indicates CMS cannot manage the program and outcomes either. He noted CMS has said most Medicaid data across the states is not very good. He stated KDHE has processes in place to ensure quality data. Another issue the Medicaid Director mentioned was the difficulty of working with encounter data because of the reprocessing of claims.

In addition, the Medicaid Director noted there have been system and personnel changes since the

audit was performed and stated the system from which LPA was given data is not the same as that then being used, and KDHE had also moved to a new data warehouse system. To ensure quality data, the Medicaid Director said there are pay-for-performance measures in place for MCOs.

The Secretary of Health and Environment noted the unfortunate timing of the audit and stated, with the current KDHE leadership team in place, many of the audit recommendations were under way before the audit report was available. Upon completion of the audit, the Secretary noted conversations with the LPA audit team during which KDHE expressed concern over the possible impact of releasing an audit with conclusions that were in question. When the audit was published, the lead articles in the leading health care news periodical stated the Kansas Medicaid information was not credible. These articles were published at the same time KDHE was negotiating with Maximus about contract non-performance. The Secretary stated part of the reason KDHE determined not to sue Maximus was the State would have difficulty proving its case in court with the reliability of the state data publicly in question.

Acting Medicaid Inspector General

At the November 8-9 meeting, the Acting Medicaid Inspector General, who was awaiting Kansas Senate confirmation, was introduced. The Office of the Medicaid Inspector General will be established under the Kansas Attorney General. The Medicaid Inspector General duties were assumed by the Acting Medicaid Inspector General after the Senate Confirmation Oversight Committee voted in favor of the nomination on October 9, 2018. The Acting Medicaid Inspector General described the duties of the office and noted the requirement the Medicaid Inspector General provide an annual report to the Kansas Legislature.

KanCare Ombudsman

The KanCare Ombudsman provided written-only updates at each of the Committee meetings on the services provided by the Office of the KanCare Ombudsman.

The number of contacts for the fourth quarter of 2017 was 1,040. The number of 2018 first-quarter contacts was 1,214 and the number during the second quarter was 1,059. In the third quarter of 2018, there were 1,085 contacts. The average quarterly initial contacts for 2018 was trending 18 percent above the 2017 quarterly average and 29 percent above the 2016 quarterly average. Two satellite offices had opened, approximately 20 hours per week each, to answer phones and help beneficiaries. Liaison training to community-based organizations was provided at six areas in Kansas; three were in western Kansas. Additionally, new data were available in the third quarter of 2018 in the form of initial contacts by region by quarter.

Presentations on KanCare from Individuals, Providers, and Organizations

Written and oral testimony was presented at each quarterly Committee meeting. Some individuals and organizations stated appreciation for the help and services provided by the MCOs and relationships developed with the MCOs that have allowed problematic issues to be addressed and resolved quickly.

Other conferees expressed gratitude for the following: KDHE's rescission of a policy that would have disallowed federally qualified health centers from dispensing discounted drugs to managed care enrolled patients; creation of the Nursing Facility Liaison Pilot Project; inclusion of recommendations for comprehensive dental benefits for adults in KanCare 2.0; MCO efforts to develop innovative approaches to health care, such as the integration of best practices into clinic workflow; a change in the policy to allow a HCBS waiver recipient to automatically continue to receive services while going through the grievance and appeals process; assistance given to one provider for the provision of Applied Behavioral Analysis (ABA) services; the 7.0 percent rate increase for HCBS waiver programs; administrative case management; support from KDHE and KDADS for local community-based services and supports coordination; the development of quality measures and metrics for KanCare; the work of the Employment System Change Coalition dedicated to expanding employment opportunities for those with disabilities; KDHE's cooperative efforts in

improving the KanCare eligibility process; positive responses received from KDADS regarding unexpected changes in the interpretation of regulations; and the expanded definition of "brain injury" that addressed a gap in services.

The following is a summary of the concerns and suggested solutions presented by conferees.

Concerns

Behavioral health. The current system does not use all the tools available to address the behavioral health crisis, and limited options for addressing the needs of individuals with behavioral health issues.

Dental care. Difficulty in finding a dental provider who accepts Medicaid, particularly oral surgeons, due primarily to the inadequate reimbursement rate.

Clearinghouse. Ongoing poor communication with the Clearinghouse and erratic service in processing applications; long delays in processing Medicaid applications resulting in nursing facility funding shortfalls, forced reductions in staff to cover cash flow problems, and the refusal of admission to elders in need of care, which in turn continues to harm the availability and quality of care for seniors; problems resolving renewal applications; and termination of coverage because of missing documentation after receipt of letters indicating "no further action was necessary" if the client did not want to change MCOs.

Application backlog. The backlog and the uncompensated care resulting from the mishandling of nursing home eligibility applications.

Supplemental Nutrition Assistance Program (SNAP) benefits. Individuals with disabilities are regularly removed from SNAP eligibility.

Targeted case management (TCM). The shift from TCM has resulted in reduced services for consumers; a need for more emphasis on self-directed care; concern the proposed KanCare 2.0 separates TCM from day and residential services; concern for the future of TCM within the managed

care structure; inadequacies of the care coordination approach; and the MCO care coordinators are removed from personal knowledge of what is required to provide long-term services and supports (LTSS) to individuals with intellectual and developmental disabilities.

Claims. Client and provider problems in resolving financial claims; extrapolation of provider error rates, requiring large repayments and resulting in 100.0 percent prepayment audits of the reviewed claim code; coding errors continue to result in denials for those transitioning from home services to nursing home facilities; and problems in receiving payment of claims due to system errors.

Credentialing. Excessively long credentialing process and a lack of uniform credentialing across MCOs.

Nursing facility surveys. Application of “immediate jeopardy” finding; lack of adherence to a rigid inspection process could result in harm to older adults in LTC facilities; ineffectiveness of surveyors due to inadequate staffing; surveyors with limited experience; high turnover rates; infrequent inspections; KDADS’ reinterpretation of existing licensure regulations that have resulted in the threat of sanctions; and surveyors ignoring the former interpretations of regulations in effect for 20 years.

Anti-psychotic drugs. Overuse of anti-psychotic drugs for dementia patients.

HCBS. Anticipated client care not provided; difficulties in obtaining attendant home care; less care and fewer services received under the managed care system; no new licenses for HCBS in Johnson County for the past four years; increasing overhead and inadequate payments provided for Medicaid patients in light of the complexity of the process; lack of integrated services; low reimbursement rates and burdensome paperwork requirements for KanCare and Medicare have resulted in some home health and hospice providers closing their doors, jeopardizing patient care for a number of service providers; delays in obtaining MCO authorization for home care; inability for providers to speak with MCO case managers to provide communication of

care updates for home health patients; difficulty in obtaining durable medical equipment for individuals; Medicaid’s institutional bias; low wages and inadequate access to training for service attendants; and concern for the weakening of provider networks, especially the shortage of home care workers.

KanCare oversight and policy guidance. Concern with the adequacy of state resources, both staff and funding, to provide oversight and guide policy for KanCare.

Protected income limit (PIL). Allowing an individual under an HCBS waiver to keep only the \$727.00 per month PIL plus a \$20.00 disregard is insufficient for living expenses and limits the individual’s ability to live a safe, healthy life.

Traumatic Brain Injury (TBI) waiver. Requirement that eligibility for TBI waiver services not begin until 16 years of age is artificial, prevents access to waiver services for younger individuals, and places a financial burden on families; the brain injury definition under the TBI waiver does not include “acquired” brain injury and prohibits the inclusion of all brain-injury survivors, although there is no difference in the needs and care for individuals with TBI and acquired brain injury; difficulty of finding any assistance from a direct service worker or a personal care attendant because of the low wage offered through KanCare for agency-directed workers; significant shortage of ABA service providers in the state; and few ABA service providers able or willing to work with KanCare due to ongoing issues and low reimbursement rates.

KanCare 2.0. Proposed changes pose a significant danger to low-income families, especially the lifetime limits proposed; uncertainty surrounding the proposal; and case managers being separated from those receiving services and providers not receiving clarification from the State or from MCOs on the contracts and the effect they will have on Kansans.

Legislative proviso. Promises to refrain from making any changes to the existing KanCare system as required by the legislative proviso have not been met.

State funding cut. Effect on all centers for independent living except the Topeka Independent Living Resource Center (TILRC).

Foster care. Increase in the number of children in foster care needing services.

Psychiatric residential treatment facilities (PRTFs). Decrease in the number of licensed beds in youth PRTFs and shorter lengths of stay.

KanCare Ombudsman program. Program is not large enough to meet the needs of clients, including legal advocacy.

Violation of consumer choice and self-direction. The requirement that only an MCO may refer an individual to the Aging and Disability Resource Center (ADRC) for initial assessment to determine eligibility for HCBS services when such referrals could previously be made by individuals or providers, and MCOs denying some consumers the option to move from a nursing facility back into the community without a third party, such as a nurse from the MCO, approving the transition.

Fingerprint-based background check. The requirement for fingerprint-based background checks eliminates a consumer's ability to make a final decision whether to hire someone, causes delays in hiring service workers, and creates problems in self-directed health care.

Transition from school to community. The need to develop programs to assist individuals with disabilities to transition from school to community.

Unfunded requirements placed on providers. Additional unfunded requirements MCOs place on health care providers.

Administrative case management RFP. RFP not yet released by KDADS.

Recommended Solutions

Elimination of the PIL to receive HCBS or put in place a long range plan to gradually increase the PIL until it is eliminated; re-institution of the Letters of Voluntary Contribution discontinued by KDHE that were sent to applicants who were

almost eligible for Medicaid notifying them they were less than one month away from spending down to the required asset level and could reach eligibility mid-month; reconsideration of the Committee recommendation to give nursing facility surveyors more latitude in interpreting deficiencies; additional oversight to address reinterpretation of existing nursing facility licensure regulations that have resulted in the threat of sanctions or surveyors ignoring former interpretations in regulations; return to TCM as an option for all waiver populations and place more emphasis on self-directed care; expansion of the availability of behavioral health services; consideration of the solutions offered in the Governor's Behavioral Health Services Planning Council's Children's Continuum of Care Task Force Report and Recommendations; increase the intensity of the oversight of the eligibility process; increase in provider reimbursement rates to accommodate increasing nursing facility overhead and the inadequacy of reimbursement provided for Medicaid patients; increase in wages for agency-directed direct service workers and personal care attendants (\$9.00 per hour) to the upper-level recommendation of \$11.04 per hour available to workers paid through self-direction; modify the definition of "brain injury" under the TBI waiver to include "acquired" brain injury or to eliminate the word "traumatic" and remove the arbitrary age limit requirement of 16 years of age or older to receive services; increase in stakeholder involvement; delay KanCare 2.0; expand KanCare; create an independent ombudsman program to provide legal advice on the appeals process and to advocate on behalf of the individual; make the Nursing Facility Liaison Pilot Project permanent; provide direct oversight of KanCare by the Legislature; address fundamental flaws in how ABA services are structured under KanCare, which would require amendment of the Medicaid State Plan; expand the TBI provider network and increase the Medicaid base rates for TBI services; create an exception to the fingerprinting requirement when writing the waiver renewals in 2019 for persons self-directing services on the physical disability (PD), frail elderly (FE), and TBI waivers; exclude LTSS from the medical model for health services; provide sufficient funding for KanCare programs and providers; provide timely quality care assurance for frail elderly adults and adults with disabilities in adult care facilities; eliminate survey delays in

nursing and assisted living facilities; continue reducing the misuse and overuse of anti-psychotic drugs to nursing facilities; improve workforce support to address the shortage of personal care attendants; and comply with the CMS Settings Final Rule (79 CFR 2947; January 16, 2014).

Conferees. Private citizens and representatives of the following organizations and providers testified or provided written-only testimony before the Committee: Alliance for a Healthy Kansas and Health Reform Resource Project; Brain Injury Association of Kansas and Greater Kansas City; Behavioral Health Association of Kansas; Case Management Services; Children's Alliance of Kansas; communityworks, inc. and Mind Matters, LLC; Country Club Estates; Disability Rights Center of Kansas; Evergreen Community of Johnson County; GrassRoots Advocates for Independent Living; Integrated Behavioral Technologies, InterHab; Jenian, Inc.; KanCare Advocates Network; Kansas Action for Children; Kansas Adult Care Executives Association; Kansas Advocates for Better Care; Kansas Association for the Medically Underserved; Kansas Association of Area Agencies on Aging and Disabilities; Kansas Association of Centers for Independent Living; Kansas Christian Home; Kansas Council on Developmental Disabilities; KFMC; KHI; Kansas Health Care Association and Kansas Center for Assisted Living; Kansas Home Care and Hospice Association; Kansas Hospital Association; Kansas Medical Society; LeadingAge Kansas; Leavitt Partners; Leukemia and Lymphoma Society; National Multiple Sclerosis Society; Oral Health Kansas; Salem Home; Self Advocate Coalition of Kansas; Solomon Valley Manor; Southeast Kansas Adult Care Executive Association; Southeast Kansas Independent Living Resource Center; Three Rivers, Inc.; TILRC; Topeka Pediatrics and Kids First Urgent Care; Villa St. Francis; and Windsor Place.

Managed Care Organization Testimony

Representatives of all three MCOs provided testimony and responses to presentations by individuals, organizations, and providers at each meeting.

UnitedHealthcare Community Plan of Kansas

Representatives from UnitedHealthcare presented a new transparency dashboard, Medicaid Insights and Transparency Initiative, managed by a third-party non-profit organization, that is designed to provide up-to-date information for the Committee. Representatives of UnitedHealthcare and the Johnson County Mental Health Center (MHC) described a pilot partnership between the MHC and UnitedHealthcare that links peer drivers with behavioral health patients. The MHC representative reported the program has improved quality-of-life outcomes, as well as lowering overall healthcare expenditures. A representative of UnitedHealthcare explained its Medicare Advantage Dual Special Needs Plan (DSNP), which is a Medicare Advantage prescription drug plan for those individuals who are dual eligible. The DSNP covers additional services not covered by Medicare or KanCare at no cost to the recipient. Presently, the DSNP serves 14 Kansas counties, representing about 50.0 percent of the total dual-eligible consumers in the state. A UnitedHealthcare representative stated, by the end of 2018, the program would provide \$40.0 million in medical and supplemental benefits and services outside of KanCare to approximately 4,000 consumers; that number is expected to grow to \$55.0 million in 2019. Pending CMS approval, UnitedHealthcare hopes to expand the DSNP in 2020 sufficient to cover the counties in which 85.0 percent of the Medicare/Medicaid dual-eligible consumers live.

Sunflower Health Plan

A representative from Sunflower reviewed Healthcare Effectiveness Data and Information Set Data and noted value-added benefits, HCBS, and extra services. The representative illustrated caregiver collaborations with a Vela Pilot Program that connects service providers with clients through a dedicated phone system and shared a video illustrating community-based collaboration. A representative from Sunflower commented the MCO has been partnering with the Kansas Association for the Medically Underserved to collect aggregate data on social determinants in order to enhance services to members. The Sunflower Medical Director introduced a new resource, Patient Analytics, and provided

information showing improved quality of care for children and adolescents. A Sunflower representative noted innovative strategies that foster integration, including telehealth and introduction of managed LTSS (MLTSS), as effective ways to expand services. Sunflower's investments in community health included more than \$91,000 in non-Medicaid in-lieu-of services and \$285,000 in Medicaid-covered services that kept members from being placed in nursing facilities. Approximately \$1.5 million in value-added benefits were provided from August through September 2018. A \$110,000 grant was used for screening and access to mental health services. A Sunflower representative cited improvements made to KanCare, including those made by the KanCare Improvement Working Group in which Sunflower participated (*e.g.*, standardized credentialing, prior authorizations, and appeals processes; a proactive claims process; and member advisory groups). Sunflower also collaborated with the Windsor Place telehealth initiative, Project Echo to launch in 2019 to focus on serious emotional disturbance (SED) telehealth services, and other advancements in integrated services. A Sunflower representative noted higher Medicaid reimbursement rates are needed to attract providers to meet the TBI service needs in Wichita.

Amerigroup Kansas Plan

A representative from Amerigroup reviewed the activities and services provided and highlighted operational performance, provider and consumer engagement, and quality of service. Community relations were illustrated with a discussion of a \$60,000 grant to the Iroquois Center for Human Development in Greensburg, Kansas, that allows the agency to expand and improve housing for special-needs adults. An Amerigroup representative introduced representatives from Finity to explain Amerigroup's Health Intelligence Program, which is an incentive program to tie members into responsible health care. An Amerigroup representative outlined the transition and decommission plans to ensure member continuity of care with the end of the Amerigroup KanCare contract. On-site leadership staff will be in place through March 31, 2019, to address run-out of claims activity and encounters, reporting needs, and anything else that needs to be addressed after

the contract runs out. Transition and plan closure will occur on December 31, 2018, and, due to timing requirements, select operations (claims, appeals, and encounters) will continue through the first quarter of 2020.

Medicaid Managed Care Study

At the February 16 meeting, a representative from Leavitt Partners reported on the second phase of the Medicaid Managed Care Study. The representative reviewed the three phases: cost and utilization patterns, which was presented to the Committee on November 28, 2017; measures of quality and access, presented to the Committee at the February 2018 meeting; and a report on performance improvement projects and other activities undertaken by the MCOs that was scheduled for release on February 20, 2018. The representative noted the study was not based on primary research by Leavitt Partners, but, rather, Leavitt Partners relied primarily on data from the KFMC, the State's external quality review organization and Section 1115 waiver demonstration evaluator; data from the National Committee for Quality Assurance; and quarterly reports from KDHE. The representative compared this data with national statistics and commented on the MCO's plans for performance improvements. The Kansas Association of Medicaid Health Plans paid for the study. The Leavitt Partners representative noted the data do not yield to cause-and-effect conclusions. Committee members expressed skepticism about exclusive use of in-house information, indicating they had expected more third-party assessments.

Human Services Consensus Caseload

Staff from the Division of the Budget, Kansas Department for Children and Families, KDHE, KDADS, and KLRD met April 17, 2018, to revise the estimates on human services caseload expenditures for FY 2018 and FY 2019, and November 1, 2018, to revise estimates on caseload expenditures for FY 2019 and to develop estimates for FY 2020 and FY 2021. The estimates include expenditures for Temporary Assistance for Needy Families, the Reintegration/Foster Care contracts, and KanCare Regular Medical Assistance and KDADS Non-KanCare.

Spring Estimate

The combined estimate for FY 2018 and FY 2019 is an all funds increase of \$108.0 million and a SGF increase of \$109.1 million above the Governor's recommended budget. The FY 2018 estimate for all human service caseloads is \$3.0 billion from all funding sources, including \$1.0 billion from the SGF. The FY 2019 estimate is \$3.4 billion from all funding sources, including \$1.2 billion from the SGF.

Fall Estimate

The estimate for FY 2019 is an increase of \$121.6 million from all funding sources and an increase of \$54.6 million from the SGF when compared with the budget approved by the 2018 Legislature. The estimate for FY 2020 is \$3.6 billion from all funds, including \$1.3 billion from the SGF. For FY 2021, the estimate for all human service caseloads is \$3.7 billion from all funding sources, including \$1.3 billion from the SGF. The combined estimate for FY 2019, FY 2020, and FY 2021 is an all funds increase of \$277.6 million and a SGF increase of \$85.1 million.

Quarterly HCBS Report

At each Committee meeting, written testimony was provided by KDADS on the average monthly caseloads and average census for state institutions and LTC facilities. A representative from KDADS provided information on savings on transfers to HCBS waivers and the HCBS Savings Fund balance. (See Appendix A for the 2018 report.) The Secretary for Aging and Disability Services stated the average daily census for the Kansas Neurological Institute and the monthly Medicaid average eligibility caseload for LTC facilities have remained steady for the past six years; the average daily census has decreased for Parsons State Hospital and Treatment Center (PSHTC).

The KDADS Commissioner of Community Services and Programs compared self-directed services with agency-directed services; summarized data on the HCBS waivers, including actual MCO paid amounts; projected the MCO capitation rate cost breakout; and provided a PACE update. The Commissioner also provided data on the average monthly caseloads for HCBS waivers, HCBS Money-Follows-the Person, LTC facilities, and state institutions; average census for

state institutions and LTC facilities; and average length of stay for PRTFs. The Secretary for Aging and Disability Services shared results from the resident satisfaction survey for Kansas nursing homes and data indicating progress in reducing the use of anti-psychotic drugs in nursing homes.

At the November 8-9 meeting, the KDHE Medicaid Director stated the CAP for MLTSS was completed in October 2018, which was confirmed by the KDADS Commissioner of Home and Community Based Services. Additionally, the Commissioner stated the operational items under the 372 CAP (form for annual report on HCBS waivers) have been jointly completed by KDADS and KDHE; the 372 CAP will remain open to meet the CMS ongoing monitoring requirements.

HCBS Waiting Lists Update

At the November 8-9 meeting, the KDADS Commissioner of Community Services and Programs reported as of October 12, 2018, the HCBS Intellectual/Developmental Disability (I/DD) waiting list had 3,785 individuals and 9,107 individuals were receiving services, and 1,600 individuals were on the HCBS PD waiting list and 5,872 individuals were receiving services. In calendar year 2018, 150 offers for HCBS services were made to individuals on the I/DD waiting list and 1,175 offers were made to individuals on the PD waiting list.

Autism Waiver

The KDADS Commissioner of Community Services and Programs stated at the April 23 meeting that KDADS has reconvened the Autism Advisory Council, with the goal of providing KDADS with recommendations on topics, including appropriate training guidelines for autism service providers and growing the provider network. The Autism Advisory Council has identified other areas of interest, including streamlining enrollment and billing processes for providers and increasing reimbursement rates. KDADS is working collaboratively with KDHE and the MCOs to address network issues for those receiving services *via* the Autism waiver. At the November 8-9 meeting, the Commissioner stated there were 265 proposed recipients for the Autism waiver as of September 30, 2018.

HCBS Policy Updates

The KDADS Commissioner of Community Services and Programs outlined HCBS policy updates, which included developing two Person-Centered Service Plan policies reflecting CMS and stakeholder feedback, one focused on I/DD services and the other on the remaining waiver populations.

Survey on Increase in HCBS Provider Rate

At the August 20-21 meeting, the Commissioner of Community Services and Programs stated, in response to a legislative request, KDADS would send a survey to providers in late August 2018 to understand how the HCBS provider rate increase for FY 2018 and FY 2019 affected direct service workers. At the November 8-9 meeting, the Commissioner stated the survey would be sent to providers by November 15 and results would be available in January 2019.

Network Adequacy Standards

At the April 23 meeting, the KDADS Commissioner of Community Services and Programs reported KDADS is proposing four types of network adequacy standards for HCBS and Behavioral Health services. KDADS and KDHE will collect monthly and quarterly data sets from the MCOs, claims data, and the Electronic Visit Verification System to track performance against the standards.

RFPs

At the August 20-21 meeting, the Commissioner of Community Services and Programs stated, in response to new budget parameters passed by the 2018 Legislature, two RFPs would be issued for administrative case management and for the ADRC. The current ADRC contracts end in March 2019. At the November 8-9 meeting, the Commissioner noted work under the new contracts is anticipated to begin on April 1, 2019.

Behavioral Health

PRTFs

The Deputy Secretary for Aging and Disability Services and KDADS Commissioner of

Behavioral Health Services (Deputy Secretary) reviewed information regarding PRTFs and the determination of “medical necessity.” Each MCO independently determines the medical necessity that allows a youth to enter a PRTF. KDHE and KDADS audit the records and review the MCOs’ decisions. A pilot program began October 1, 2017, and ended April 1, 2018, which entailed community mental health centers (CMHCs) and the MCOs engaging children on the PRTF wait list and their families in intensive community services. The pilot allowed the CMHCs to complete implementation of Community Based Services Teams (CBSTs), and the MCOs paid an enhanced rate for each CBST. The differences in the number of PRTF patients per MCO is partially determined by the population served by the MCO. The Deputy Secretary also cited possible alternatives to avoid institutional placement.

The Deputy Secretary stated at the August 20-21 meeting KDADS and KDHE clinical staff have recently initiated audits of “medical necessity” and denials being completed in response to concerns regarding inconsistent admissions at PRTFs. The Deputy Secretary noted the PRTF pilot ended in April 2018. There are questions on how well the pilot worked; if KDADS continues with the pilot, changes will need to be made. The Deputy Secretary mentioned a national study on PRTFs being conducted by the National Association of State Mental Health Program Directors Research Institute.

At the November 8-9 meeting, the Deputy Secretary noted there is a shortage of PRTF beds in the state. The Deputy Secretary reviewed the issue of “medical necessity,” which MCOs use to determine juvenile placement in a PRTF. A representative of KFMC commented the MCOs do not use the same criteria to determine medical necessity. KFMC has begun an audit to determine whether the requests for admission to a PRTF met the MCOs’ admission criteria and guidelines and whether the requests for continued stay in a PRTF met the criteria. The 20 denial cases audited to date had confirmed the decisions made by the MCOs. KDADS was downloading 180 additional files for KFMC review to determine the contract cost to complete the audit of the remaining files. Data were provided on the average length of stay in a PRTF for all Medicaid beneficiaries by MCO and the PRTF waiting list by MCO. Prompted by

the PRTF waiting list of 125 juveniles on Medicaid, the National Association of State Mental Health Program Directors Research Institute is conducting a study for KDADS to look at data and trend analysis on PRTF bed utilization and wait lists and reviewing policies and procedures related to admission and placement processes.

Behavioral Health Intensive Crisis Services Initiatives

At the April 23 meeting, the Deputy Secretary stated KDADS is coordinating with other state agencies and the MCOs to provide behavioral health intensive crisis services for youth and their families. The proposed initiatives will be assisted by a four-year System of Care grant for children and youth with SED, which includes wrap-around community services for youth and families. During the grant period, KDADS staff will develop a sustainability plan and move toward a statewide system of care. KDADS developed an RFP posted in April 2018 to establish enhanced crisis administration services, including a 24-hour crisis hotline and mobile response for all populations. Follow-up information on the RFP was provided at the August meeting.

Housing First Bridge Pilot Program

The Deputy Secretary noted at the August 20-21 meeting four Kansas sites were selected to participate in a Housing First Bridge Pilot Program, which is a pilot project to provide safe housing for individuals with co-occurring behavioral health issues who will be connected to Housing and Urban Development entry sites upon completion of detox and residential substance abuse programming.

Kansas Client Placement Criteria

At the November 8-9 meeting, the Secretary for Aging and Disability Services explained the website application for the Kansas Client Placement Criteria screening and assessment tool used by SUD providers to determine the level of care for patients was taken offline due to confidentiality concerns and moved to manual back-up procedures. A review of the system is continuing to determine whether the system can be restored without confidentiality concerns or

whether an outside vendor will be necessary to look at other system options.

National Association of States United for Aging and Disabilities (NASUAD) Presentation

A representative of NASUAD presented information about NASUAD and a national perspective on MLTSS. Supplemental information showing the strategies for success in MLTSS and demonstrating the value of MLTSS was also provided. The NASUAD representative noted state examples of how the MLTSS program has rebalanced spending, improved health outcomes, reduced waiting lists, increased budget predictability, and managed costs.

Adult Care Home Receiverships

The Secretary for Aging and Disability Services commented at the April 23 meeting on the insolvency of Skyline Health Care, which operates 15 adult care homes in Kansas. State statutes allow the Secretary for Aging and Disability Services to become a receiver, and, under specific conditions, operate an adult care home. The Secretary filed applications for receivership in 13 Kansas district courts; the Kansas Supreme Court granted a request to consolidate the 15 actions and transferred venue to the Johnson County District Court. The Secretary was appointed as the temporary receiver and, under that authority, used Civil Monetary Penalty Fund (Fund) moneys to meet payroll and other expenses to keep the 15 facilities open until a buyer can be found. An agreement was entered into with Missions Health of Georgia, LLC, to oversee the management of the 15 facilities. Respondents to the Skyline action consented to the appointment of the Secretary as the receiver of the 15 adult care homes.

The Secretary for Aging and Disability Services provided an update on the Skyline receivership at the August 20-21 meeting, noting the difficulty in finding new operators for the facilities in receivership. The Secretary commented, of the \$4.5 million from the Fund used initially to fund Skyline, \$1.0 million had been returned and another \$1.0 million would be returned to the Fund soon. He noted two other

receiverships, Fort Scott and Great Bend, had been added.

At the November 8-9 meeting, the Secretary for Aging and Disability Services explained, when the receiverships began, the Fund had \$5.6 million. A total of about \$4.6 million was used to fund the 15 Skyline receivership facilities initially, \$2.6 million of which had since been returned to the Fund. KDADS continued to meet with the Skyline landlord as the landlord sought to find operators for the insolvent facilities. The Secretary stated KDADS is not paying rent to the Skyline landlord and would not do so until the Fund moneys have been replaced. The Secretary stated KDADS has had health insurance in place for the Skyline employees since April 1, 2018. The insurance is like that previously offered but not paid for by Skyline. KDADS had filed a federal lawsuit against Skyline and its principals seeking to hold them accountable for the Fund amounts and for failure to fulfill their obligations. KDADS took receivership of three additional facilities (Pinnacle receivership) due to multiple concerns, including the operators having used resident trust funds to meet payroll expenses. The owner of the Pinnacle receivership properties had agreed to repay the approximately \$1.0 million paid by the Fund upon the sale of the properties. The Secretary provided information on the status of three additional receiverships (Fort Scott, Great Bend, and Westview of Derby) and indicated completion of the State's receivership was anticipated in the near future with nearly all of the moneys paid by the Fund to be returned.

Oversight of LTC Facilities

At the February 16 meeting, the KDADS Commissioner of Survey, Certification, and Credentialing reviewed the LTC survey information, especially noting the need for more surveyors. The fines for non-compliance, the number of "immediate jeopardy" findings of surveyors, and the increase in criminal background checks as a result of a new law were noted. The Commissioner indicated the increase in penalties in 2016 for the first time since 1990 was due to inflation.

The Secretary for Aging and Disability Services updated the Committee on the LTC surveys at the April 23 meeting. The Secretary

noted CMS survey regulations were revised, and all KDADS surveyors have been trained on the new survey process, the new federal regulations, and the revised CMS interpretive guidelines. KDADS survey policies and procedures would be reviewed and revised to incorporate the CMS changes. The Secretary expressed concern for the delays in completing surveys within the time required. In an effort to address the survey delays, the agency planned to train licensed practical nurse surveyors to complete portions of the surveys, allowing the registered nurse (RN) surveyors to concentrate on those survey tasks that require their knowledge and skills. The Secretary stated KDADS planned to request enhanced funding from the Legislature to raise RN surveyor salaries sufficiently to attract applicants.

At the August 20-21 meeting, the Secretary for Aging and Disability Services reported that the vendor HMS was assisting with surveys and provided data updates on the annual and complaint surveys and the status of current surveyor positions. The Secretary stated the recent pay increases helped in recruiting and retaining survey staff. The Secretary also noted the increase in the number of criminal record background checks since 2015, a recent requirement for HCBS and behavioral health. In response to a Committee question, the Deputy Secretary replied when complaints about LTC facilities are received, they are prioritized by severity with responses within the time frames required by CMS criteria. The immediate jeopardy complaints and other more serious ones are responded to immediately. Separate staff are responsible for the complaint surveys, so response to those does not take staff away from the annual surveys.

The Secretary for Aging and Disability Services stated at the November 8-9 meeting CMS planned to withhold a \$1.0 million payment if the LTC survey backlog was not addressed. The Secretary reviewed data reflecting an increase in the number of LTC surveys completed since June 2018. The Secretary also provided data on the immediate jeopardy citations, which had decreased in 2018 relative to 2016 and 2017 due in part to a change in CMS interpretation and guidance and additional staff training. The surveyor vacancies were down from 17 to 8.

State Hospitals

Electronic Medical Record System

The Secretary for Aging and Disability Services commented at the August 20-21 meeting on a new contract with vendor Navigant Consulting to evaluate the disparate billing and electronic medical records (EMR) systems in place at each of the four state hospitals. At the November 8-9 meeting, the Secretary discussed the EMR assessment findings of the comprehensive review conducted by Navigant Consulting that identified core functionality gaps and support the need for KDADS and state hospitals to pursue strategic modernization of EMR system functionality, which will require procurement of a new EMR system. KDADS issued a request for information from potential vendors and hopes to have an RFP for the 2019 Legislature to consider. KDADS planned to submit a budget request for the initial implementation and annual ongoing support for a new EMR system.

Osawatomie State Hospital

Re-accreditation; vacancy and overtime rates. At each Committee meeting, the Secretary for Aging and Disability Services reported on Osawatomie State Hospital (OSH). OSH has been re-accredited, with a follow-up survey by The Joint Commission and another by KDHE. Data on the newly certified Adair Acute Care at OSH, staff changes, and statistics identifying overtime trends and vacancies were provided. At the November 8-9 meeting, the Secretary stated vacancy rates and overtime at OSH were improving and provided supporting data.

Privatization considerations. At the February 16 meeting, the Secretary for Aging and Disability Services responded to members' questions, stating if CorrectCare would be the vendor to operate OSH if the hospital were privatized, then the Legislature's approval would be required before a contract could be signed. He stated two RFPs were submitted for privatization, and regional hospitals might be considered rather than moving Larned State Hospital (LSH) to a new location.

At the April 23 meeting, the Secretary for Aging and Disability Services stated KDADS is continuing to negotiate with a vendor to privatize

OSH, and an additional consideration is to issue a RFP for a regional model to add beds. Members were assured that any privatization proposal would be brought to the Legislature as required by statute and the proviso prohibiting privatization without legislative approval. The Secretary mentioned the Mental Health Task Force would continue to meet and assist in developing a strategic plan to address behavioral health needs.

The Secretary for Aging and Disability Services provided details at the August 20-21 meeting on the RFP to increase regional beds and the input being received from the Mental Health Task Force on the RFP and the regionalization process moving forward; the hope was to have the RFP out in September, bids back by the end of 2018, and the process to the Legislature in 2019.

Structural integrity of buildings. At the February 16 meeting, the Secretary for Aging and Disability Services outlined pending decisions regarding the lack of structural integrity of many of the buildings at OSH. The Secretary commented on two provisos in 2017 Senate Sub. for HB 2002. One proviso focused on the structural integrity of all the buildings and the second determined the cost of a 100-bed stand-alone facility. The Secretary identified the buildings that should be razed and those that could be renovated, and a sequential time line for the work. Estimates for a 100-bed hospital (\$40.2 million to \$52.3 million) and a 200-bed facility (\$58.3 million to \$75.7 million) were also provided.

Larned State Hospital

At the February 16 meeting, the Secretary for Aging and Disability Services reported on LSH, including a review of the staff vacancy and overtime rates. The Secretary also addressed the certification of the units at LSH, whether any facility repairs were still required, and how incidents of abuse and neglect that were not reported were being addressed. At the November 8-9 meeting, the Secretary noted challenges remained at LSH related to vacancy rates and overtime.

At the November 8-9 meeting, the Secretary indicated a regional bed model might help alleviate the staffing and need for beds at both

OSH and LSH by spreading the state hospital population throughout the state to allow the patients to be closer to home and provide better care for the patients. The Secretary added KDADS prepared a RFP to develop a regional bed model, which was being reviewed by the Department of Administration

Parsons State Hospital and Training Center

The Secretary for Aging and Disability Services stated at the August 20-21 meeting PSHTC was out of CMS compliance with regard to facility staffing related to physical therapy during the May 2018 annual survey. The Secretary stated CAPs were in place to bring the hospital into compliance. The Superintendent of PSHTC discussed the CAPs for the annual and complaint surveys. The Superintendent noted an Administrative Executive Committee had been added to assist with the CAPs, as well as evaluate other areas for possible noncompliance. Regarding the July 2018 PSHTC complaint survey related to nursing and which resulted in an immediate jeopardy finding, the Superintendent said a new policy was being implemented to assist with documentation. The final survey reports for the annual and complaint surveys were expected to be available soon after that meeting.

At the November 8-9 meeting, the Secretary for Aging and Disability Services commented the deficiency cited during the PSHTC CMS/KDHE annual survey in May 2018 related to physical therapy staffing was corrected. The complaint survey related to nursing on July 2, 2018, that resulted in immediate jeopardy, was abated on July 17, 2018. On October 30, 2018, KDHE surveyors reported PSHTC was in compliance with all conditions related to the annual and complaint surveys.

Update on Renewal of HCBS Waivers

At the August 20-21 meeting, the KDADS Commissioner of Community Services and Programs stated four HCBS waivers that expire in 2019 are scheduled for renewal: the I/DD, TBI, FE, and PD waivers. The Commissioner noted changes in the TBI waiver to include acquired brain injury as part of the waiver renewal process, the development of KanCare proposed HCBS and behavioral health network adequacy standards, the

data from the National Core Indicators survey, and the implementation and training on the Person-Centered Service Plan policy.

Program for All-Inclusive Care for the Elderly

A Committee member requested information comparing the cost of treatment under PACE to the cost in an institutional setting. KDADS provided the 2013 PACE Medicaid Cost-Benefit Study conducted by the Office of Aging and Long Term Care of the University of Kansas School of Social Welfare.

Update on Kansas University School of Social Welfare Medicaid Contract

The KDADS Commissioner of Financial and Information Services provided an update on the Kansas University School of Social Welfare Medicaid contract at the February 16 meeting. The Commissioner indicated the University self-reported the overpayment of federal Medicaid funds and had conducted due diligence in ensuring the audit was performed accurately.

Telemonitoring. At the November 8-9 meeting, a representative of Windsor Place reviewed an initiative to enable nursing home candidates to remain in their homes for an extended period of time through the use of self-managed medical technology. Windsor Place provides remote patient monitoring with software-driven devices placed in high-risk patients' homes and remote health coaching aimed at moderate-risk patients. The representative recommended broader adoption of remote patient monitoring for not only individuals on the FE waiver, but for all individuals on HCBS waivers, as a means of offering significant savings to KanCare MCOs and the state.

Presentation by Aetna Better Health of Kansas, Inc.

Aetna is the new MCO awarded a KanCare managed care contract to begin January 1, 2019. A representative of Aetna reviewed the company's history and experience at the November 8-9 meeting. The representative noted the implementation status since the awarding of the KanCare contract was on track and outlined

Aetna's system of care. Aetna offers Medicare Advantage programs in Kansas and expanded options for dual-eligible Medicaid members with the addition of DSNP members in Johnson and Sedgwick counties in 2019 and plans to expand to more counties in 2020.

Marketplace Update

The Director of Health and Life, Kansas Insurance Department, provided a written-only federal health insurance marketplace update at the February 16 meeting.

CONCLUSIONS AND RECOMMENDATIONS

The Committee adopted the following recommendations:

- The KDADS RFP for high-touch administrative case management at the local level be monitored;
- A request be made for a report on progress made in nursing facility inspections toward compliance with federal and state law requiring inspections every 12 months;
- Recognizing suicide is the second leading cause of death among individuals ages 15-24 and ages 25-44 and the Kansas suicide rate in 2013 was 16.7 percent higher than the national average, according to the 2014 Kansas Annual Summary of Vital

Statistics from KDHE, the Committee expresses its concern to the Mental Health Task Force regarding the suicide rate and recommends the Task Force continue to study to identify causes and develop mitigating tools; and

- KDHE and KDADS continue to monitor and report to the legislative health and budget committees on the efforts to reduce the waiting lists for the PD and I/DD HCBS waivers and the KanCare Medicaid eligibility backlog.

The Committee expressed concerns about the lack of preventive dental care for adult Medicaid recipients.

The Committee proposed the following legislation:

- A Committee bill be drafted to lift the PIL cap. [*Note:* A Committee member noted the PIL had not been reviewed or updated in about 20 years and is one of the lowest in the country];
- A Committee bill be pre-filed to restore the TANF eligibility profile to its 2010 level; and
- The 2018 dental therapist bill (2018 SB 312, as it passed the Senate) be introduced as a Committee bill in the 2019 Legislative Session.

APPENDIX A

ROBERT G. (BOB) BETHELL JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES AND KANCARE OVERSIGHT

ANNUAL REPORT FOR THE 2018 LEGISLATIVE SESSION

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight is charged by statute to submit an annual written report on the statewide system for long-term care services to the President of the Senate and the Speaker of the House of Representatives at the start of each regular legislative session. The authorizing statute (KSA 2018 Supp. 39-7,159) creating a comprehensive and coordinated statewide system for long-term care services became effective July 1, 2008.

The Committee's annual report is to be based on information submitted quarterly to the Committee by the Secretary for Aging and Disability Services. The annual report is to provide:

- The number of individuals transferred from state or private institutions to home and community based services (HCBS), including the average daily census in state institutions and long-term care facilities;
- The savings resulting from the transfer of individuals to HCBS as certified by the Secretary for Aging and Disability Services; and
- The current balance in the Home and Community Based Services Savings Fund.

The following tables and accompanying explanations are provided in response to the Committee's statutory charge.

Number of Individuals Transferred from State or Private Institutions to HCBS, Including the Average Daily Census in State Institutions and Long-term Care Facilities

Number of Individuals Transferred—The following table provides a summary of the number of individuals transferred from intellectual/developmental disability (I/DD) institutional settings into HCBS during state fiscal year 2018, together with the number of individuals added to HCBS due to crisis or other eligible program movement during state fiscal year 2018. The following abbreviations are used in the table:

- ICF/MR — Intermediate Care Facility for the Mentally Retarded
- SMRH — State Mental Retardation Hospital
- MFP — Money Follows the Person program
- SFY — State Fiscal Year

I/DD INSTITUTIONAL SETTINGS AND WAIVER SERVICES*	
Private ICFs/MR: Average Monthly Caseload SFY 2018	137
State I/DD Hospitals – SMRH: Average Monthly Caseload SFY 2018	294
MFP I/DD: Number discharged into MFP program – I/DD SFY 2018	20
I/DD Waiver Community Services: Average Monthly Caseload SFY 2018	9,043
*Monthly averages are based upon program eligibility.	
Sources: SFY 2018—Medicaid eligibility data as of November 8, 2018. The data include people coded as eligible for services or temporarily eligible.	

The following table provides a summary of the number of individuals transferred from nursing facility institutional settings into HCBS during SFY 2018. The caseload has been decreasing in SFY 2018 as the MFP federal grant is winding down. Kansas stopped MFP transitions in July 2017; individuals transitioning by that time have 365 days of MFP, after which they are transitioned to the appropriate HCBS program. These additional abbreviations are used in the table:

- FE — Frail Elderly Waiver
- PD — Physical Disability Waiver
- TBI—Traumatic Brain Injury Waiver

FE / PD / TBI INSTITUTIONAL SETTINGS AND WAIVER SERVICES*	
Nursing Homes-Average Monthly Caseload SFY 2018	10,049
MFP FE: Number discharged into MFP program receiving FE Services	49
MFP PD: Number discharged into MFP program receiving PD Services	83
MFP TBI: Number discharged into MFP program receiving TBI Services	4
Head Injury Rehabilitation Facility	34
FE Waiver: Average Monthly Caseload SFY 2018	4,676
PD Waiver: Average Monthly Caseload SFY 2018	5,897
TBI Waiver: Average Monthly Caseload SFY 2018	434
*Monthly averages are based upon program eligibility.	
Sources: SFY 2018—Medicaid eligibility data as of November 8, 2018. The data include people coded as eligible for services or temporarily eligible.	

**AVERAGE DAILY CENSUS IN STATE INSTITUTIONS AND
LONG-TERM CARE FACILITIES**

Kansas Neurological Institute: Average Daily Census

FY 2012 – 152
FY 2013 – 145
FY 2014 – 143
FY 2015 – 144
FY 2016 – 141
FY 2017 – 142
FY 2018 – 140

Parsons State Hospital: Average Daily Census

FY 2012 – 175
FY 2013 – 176
FY 2014 – 174
FY 2015 – 173
FY 2016 – 163
FY 2017 – 160
FY 2018 – 160

Private ICFs/MR: Monthly Average*

FY 2012 – 166
FY 2013 – 155
FY 2014 – 143
FY 2015 – 140
FY 2016 – 137
FY 2017 – 133
FY 2018 – 137

Nursing Facilities: Monthly Average*

FY 2012 – 10,761
FY 2013 – 10,788
FY 2014 – 10,783
FY 2015 – 10,491
FY 2016 – 10,235
FY 2017 – 10,047
FY 2018 – 10,049

*Monthly averages are based upon Medicaid eligibility data.

Savings Resulting from the Transfer of Individuals to HCBS

The “savings” through MFP are realized only if and when an individual is moved into a community setting from an institutional setting and the bed is closed. This process would result in a decreased budget for private ICFs/MR and an increase in the I/DD (HCBS I/DD) Waiver budget as a result of the transfers.

For nursing facilities and state ICFs/MR, the process is consistent with regard to individuals moving to the community. The difference is seen in “savings.” As stated above, savings are seen only if the bed is closed. In nursing facilities and state ICFs/MR, the beds may be refilled when there is a request by an individual for admission that requires the level of care provided by that facility. Therefore, the beds are not closed. Further, even when a bed is closed, only incremental savings are realized in the facility until an entire unit or wing of a facility can be closed.

As certified by the Secretary for Aging and Disability Services, despite individuals moving into community settings that does have the effect of cost avoidance, the savings resulting from moving the individuals to home and community based services, as of December 31, 2018, was \$0.

Balance in the KDADS Home and Community Based Services Savings Fund

The balance in the Kansas Department for Aging and Disability Services Home and Community Based Services Savings Fund as of December 31, 2018, was \$0.